(B) in the case the individual is not described in subparagraph (A) and not enrolled in a Federal health care program, the individual.

(July 1, 1944, ch. 373, title XXVII, § 2799B–6, as added Pub. L. 116–260, div. BB, title I, § 112, Dec. 27, 2020, 134 Stat. 2866.)

§ 300gg–137. Patient-provider dispute resolution

(a) In general

Not later than January 1, 2022, the Secretary shall establish a process (in this subsection referred to as the ''patient-provider dispute resolution process'') under which an uninsured individual, with respect to an item or service, who received, pursuant to section 300gg–136 of this title, from a health care provider or health care facility a good-faith estimate of the expected charges for furnishing such item or service to such individual and who after being furnished such item or service by such provider or facility is billed by such provider or facility for such item or service for charges that are substantially in excess of such estimate, may seek a determination from a selected dispute resolution entity for the charges to be paid by such individual (in lieu of such amount so billed) to such provider or facility for such item or service. For purposes of this subsection, the term ''uninsured individual'' means, with respect to an item or service, an individual who does not have benefits for such item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program (as defined in section 1320a–7b(f) of this title), or a health benefits plan under chapter 89 of title 5 (or an individual who has benefits for such item or service under a group health plan or individual or group health insurance coverage offered by a health insurance issuer, but who does not seek to have a claim for such item or service submitted to such plan or coverage).

(b) Selection of entities

Under the patient-provider dispute resolution process, the Secretary shall, with respect to a determination sought by an individual under subsection (a), with respect to charges to be paid by such individual to a health care provider or health care facility described in such paragraph for an item or service furnished to such individual by such provider or facility, provide for—

(1) a method to select to make such determination an entity certified under subsection (d) that—

(A) is not a party to such determination or an employee or agent of such party;

(B) does not have a material familial, financial, or professional relationship with such a party; and

(C) does not otherwise have a conflict of interest with such a party (as determined by the Secretary); and

(2) the provision of a notification of such selection to the individual and the provider or facility (as applicable) party to such determination.

An entity selected pursuant to the previous sentence to make a determination described in such sentence shall be referred to in this subsection as the ''selected dispute resolution entity'' with respect to such determination.

(c) Administrative fee

The Secretary shall establish a fee to participate in the patient-provider dispute resolution process in such a manner as to not create a barrier to an uninsured individual's access to such process.

(d) Certification

The Secretary shall establish or recognize a process to certify entities under this subparagraph.[1] Such process shall ensure that an entity so certified satisfies at least the criteria specified in section 300gg–111(c) of this title.

(July 1, 1944, ch. 373, title XXVII, § 2799B–7, as added Pub. L. 116–260, div. BB, title I, § 112, Dec. 27, 2020, 134 Stat. 2867.)

§ 300gg–138. Continuity of care

A health care provider or health care facility shall, in the case of an individual furnished items and services by such provider or facility for which coverage is provided under a group health plan or group or individual health insurance coverage pursuant to section 300gg–113 of this title, section 9818 of title 26, or section 1185g of title 29—

(1) accept payment from such plan or such issuer (as applicable) (and cost-sharing from such individual, if applicable, in accordance with subsection (a)(2)(C) of such section 300gg–113 of this title, 9818 of title 26, or 1185g of title 29) for such items and services as payment in full for such items and services; and

(2) continue to adhere to all policies, procedures, and quality standards imposed by such plan or issuer with respect to such individual and such items and services in the same manner as if such termination had not occurred.

(July 1, 1944, ch. 373, title XXVII, § 2799B–8, as added Pub. L. 116–260, div. BB, title I, § 113(d), Dec. 27, 2020, 134 Stat. 2873.)

§ 300gg–139. Provider requirements to protect patients and improve the accuracy of provider directory information

(a) Provider business processes

Beginning not later than January 1, 2022, each health care provider and each health care facility shall have in place business processes to ensure the timely provision of provider directory information to a group health plan or a health insurance issuer offering group or individual health insurance coverage to support compliance by such plans or issuers with section 300gg–115(a)(1) of this title, section 1185i(a)(1) of title 29, or section 9820(a)(1) of title 26, as applicable. Such providers shall submit provider directory information to a plan or issuers, at a minimum—

(1) when the provider or facility begins a network agreement with a plan or with an issuer with respect to certain coverage;

(2) when the provider or facility terminates a network agreement with a plan or with an issuer with respect to certain coverage;

[1] So in original.

(3) when there are material changes to the content of provider directory information of the provider or facility described in section 300gg–115(a)(1) of this title, section 1185i(a)(1) of title 29, or section 9820(a)(1) of title 26, as applicable; and

(4) at any other time (including upon the request of such issuer or plan) determined appropriate by the provider, facility, or the Secretary.

(b) Refunds to enrollees

If a health care provider submits a bill to an enrollee based on cost-sharing for treatment or services provided by the health care provider that is in excess of the normal cost-sharing applied for such treatment or services provided in-network, as prohibited under section 300gg–115(b) of this title, section 1185i(b) of title 29, or section 9820(b) of title 26, as applicable, and the enrollee pays such bill, the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount for the treatment or services involved, plus interest, at an interest rate determined by the Secretary.

(c) Limitation

Nothing in this section shall prohibit a provider from requiring in the terms of a contract, or contract termination, with a group health plan or health insurance issuer—

(1) that the plan or issuer remove, at the time of termination of such contract, the provider from a directory of the plan or issuer described in section 300gg–115(a) of this title, section 1185i(a) of title 29, or section 9820(a) of title 26, as applicable; or

(2) that the plan or issuer bear financial responsibility, including under section 300gg–115(b) of this title, section 1185i(b) of title 29, or section 9820(b) of title 26, as applicable, for providing inaccurate network status information to an enrollee.

(d) Definition

For purposes of this section, the term ''provider directory information'' includes the names, addresses, specialty, telephone numbers, and digital contact information of individual health care providers, and the names, addresses, telephone numbers, and digital contact information of each medical group, clinic, or facility contracted to participate in any of the networks of the group health plan or health insurance coverage involved.

(e) Rule of construction

Nothing in this section shall be construed to preempt any provision of State law relating to health care provider directories.

(July 1, 1944, ch. 373, title XXVII, § 2799B–9, as added Pub. L. 116–260, div. BB, title I, § 116(e), Dec. 27, 2020, 134 Stat. 2887.)

SUBCHAPTER XXVI—NATIONAL ALL-HAZARDS PREPAREDNESS FOR PUBLIC HEALTH EMERGENCIES

CODIFICATION

Pub. L. 109–417, title I, § 101(1), Dec. 19, 2006, 120 Stat. 2832, substituted ''NATIONAL ALL-HAZARDS PREPAREDNESS FOR PUBLIC HEALTH EMERGENCIES'' for ''NATIONAL PREPAREDNESS FOR BIOTERRORISM AND OTHER PUBLIC HEALTH EMERGENCIES'' in heading.

PART A—NATIONAL ALL-HAZARDS PREPAREDNESS AND RESPONSE PLANNING, COORDINATING, AND REPORTING

CODIFICATION

Pub. L. 109–417, title I, § 101(2), Dec. 19, 2006, 120 Stat. 2832, substituted ''National All-Hazards Preparedness'' for ''National Preparedness'' in heading.

§ 300hh. Public health and medical preparedness and response functions

(a) In general

The Secretary of Health and Human Services shall lead all Federal public health and medical response to public health emergencies and incidents covered by the National Response Plan developed pursuant to section 314(6)[1] of title 6, or any successor plan.

(b) Interagency agreement

The Secretary, in collaboration with the Secretary of Veterans Affairs, the Secretary of Transportation, the Secretary of Defense, the Secretary of Homeland Security, and the head of any other relevant Federal agency, shall establish an interagency agreement, consistent with the National Response Plan or any successor plan, under which agreement the Secretary of Health and Human Services shall assume operational control of emergency public health and medical response assets, as necessary, in the event of a public health emergency, except that members of the armed forces under the authority of the Secretary of Defense shall remain under the command and control of the Secretary of Defense, as shall any associated assets of the Department of Defense.

(July 1, 1944, ch. 373, title XXVIII, § 2801, as added Pub. L. 107–188, title I, § 101(a), June 12, 2002, 116 Stat. 596; amended Pub. L. 109–417, title I, § 101(2), Dec. 19, 2006, 120 Stat. 2832.)

REFERENCES IN TEXT

Section 314(6) of title 6, referred to in subsec. (a), was in the original ''section 502(6) of the Homeland Security Act of 2002'', and was translated as meaning section 504(6) of Pub. L. 107–296, to reflect the probable intent of Congress and the renumbering of section 502 as 504 by Pub. L. 109–295, title VI, § 611(8), Oct. 4, 2006, 120 Stat. 1395.

AMENDMENTS

2006—Pub. L. 109–417 amended section generally. Prior to amendment, section consisted of subsecs. (a) to (d) relating to a national preparedness plan for carrying out health-related activities to prepare for and respond effectively to bioterrorism and other public health emergencies.

GUIDANCE FOR PARTICIPATION IN EXERCISES AND DRILLS

Pub. L. 116–22, title III, § 306, June 24, 2019, 133 Stat. 941, provided that: ''Not later than 2 years after the date of enactment of this Act [June 24, 2019], the Secretary of Health and Human Services shall issue final guidance regarding the ability of personnel funded by

[1] See References in Text note below.